COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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December 1, 2017

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.,
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones

SUBJECT: Report on Managed Care Pharmacy Benefit Manager (PBM) Transparency

Item 310 V of the 2017 Appropriations Act states the Director, the Department of Medical Assistance Services, shall include language in all managed care contracts, for all department programming, requiring the plan sponsor to report quarterly, for all quarters through the one ending June 30, 2019, to the department for all pharmacy claims; the amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager. In the event there is a difference between these amounts, the plan sponsor shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. All data and information provided by the plan sponsor shall be kept secure; and notwithstanding any other provision of law, the department shall maintain the confidentiality of the proprietary information and not share or disclose the proprietary information contained in the report or data collected with persons outside the department. Only those department employees involved in collecting, securing and analyzing the data for the purpose of preparing the report shall have access to the proprietary data. The department shall provide a report using aggregated data only to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of this initiative and its impact on program expenditures by December 1, 2017. Nothing in the report to the Chairmen of the House Appropriations and Senate Finance Committees shall contain confidential or proprietary information.

Should you have any questions or need additional information about this report, please feel free to contact me at (804) 786-8099.

CBJ/
Enc.

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Managed Care Pharmacy Benefit Manager (PBM) Transparency Report

A Report to the Virginia General Assembly — *December 1, 2017*

Report Mandate:

Item 310 V of the 2017 Appropriations Act states the Director, the Department of Medical Assistance Services, shall include language in all managed care contracts, for all department programming, requiring the plan sponsor to report quarterly, for all quarters through the one ending June 30, 2019, to the department for all pharmacy claims; the amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager. In the event there is a difference between these amounts, the plan sponsor shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. All data and information provided by the plan sponsor shall be kept secure; and notwithstanding any other provision of law, the department shall maintain the confidentiality of the proprietary information and not share or disclose the proprietary information contained in the report or data collected with persons outside the department. Only those department employees involved in collecting, securing and analyzing the data for the purpose of preparing the report shall have access to the proprietary data. The department shall provide a report using aggregated data only to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of this initiative and its impact on program expenditures by December 1, 2017. Nothing in the report to the Chairmen of the House Appropriations and Senate Finance Committees shall contain confidential or proprietary information.

Background

Enhanced pharmaceutical price transparency regarding provider payments, administrative fees, negotiated discounts, and rebates will provide the Virginia Department of Medical Assistance Services (DMAS) with the information and tools required to better evaluate pricing models utilized by the DMAS-contracted Medicaid managed care organizations (MCOs).

MCOs contract with pharmacy benefit managers (PBMs) to perform tasks related to pharmacy claim processing and benefit administration. The functions and services provided by the PBM may include, but are not limited to, prescription claim adjudication and pricing, provider network management, formulary and benefit management, and supplemental rebate negotiations.

To increase the transparency of the relationships between MCOs and PBMs, DMAS amended its contract with the MCOs to now require disclosure of the

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

contract terms that the MCOs have with their contracted PBMs. Broadly speaking, contract arrangements follow one of two pricing models: pass-through pricing or spread pricing. Pricing variance in these models center around the amount paid to the pharmacy providing the medication and the amount that an MCO reports to the department as their amount paid to the PBM for the prescription. A pass-through pricing model means that there is no expected difference in the PBM to pharmacy and MCO to PBM reported payment amounts. In a spread model, the PBM may leverage pharmacy network reimbursement rates negotiated on the PMB's full volume of prescriptions to pay pharmacies at a much larger discount from a published price. The resulting final prescription price paid to the pharmacy is calculated using the PBM's discounted rate while the PBM charges a reimbursement rate to the MCO that does not utilize the negotiated deep discount. This results in a difference or spread between the full discount amount paid to the pharmacy provider and the higher amount charged to the MCO. This difference between those two prices is referred to as the spread and results in a higher payment amount to the PBM by the MCO. Variations of these models exist in the public and private sector, and each offers different limitations and advantages. DMAS strives to review and identify the relative issues and merits of the pricing models deployed in the Virginia Medicaid Managed Care program and the fiscal impact on the Commonwealth and will do so when sufficient data permits the Agency to make informed decisions.

The mandate from the General Assembly requires the collection of additional price elements present in claim response transactions between the PBM and the submitting pharmacy, which DMAS obtained as components of the MCO encounter submission process. This additional claim-level detail provides the basis for comparing the actual amount paid to pharmacies to the amount that the PBM charged the MCO for the transaction. Comparing actual reimbursement to pharmacy providers also provides DMAS the opportunity to ensure that PBM reimbursement rates to pharmacies do not fall below the acquisition prices which could place pharmacy providers in a negative fiscal position and could result in pharmacies deciding not to participate or accept Medicaid prescriptions.

To ensure the security of reported data, the data elements representing actual pharmacy payment details were removed from inbound encounter claims through an automated process and placed in a secure, password-protected Oracle data table. Access to the data is restricted to DMAS employees engaged in data analysis for this report. As an additional security measure, the final claim identifier and the MCO are excluded from the pricing data in the Oracle table. Another distinct process must then be executed in order to compare the actual pharmacy payment to the MCO-reported payment to the PBM for the prescription. The resulting data set is protected by a second unique password created by and known only to the data analyst.

The report detail below consists of aggregated data from available MCO prescriptions (referred to as encounters) and contains no proprietary or confidential details regarding plans, products, or pricing algorithms.

Observations and Analysis of Reported MCO Prescription Data

A total of 2,833,613 prescription encounter records were submitted to DMAS between July 1, 2017 and September 30, 2017. Each transaction was evaluated for the presence of necessary data elements to complete the review. The following encounters were excluded from the analysis for the reasons noted below:

- 259,309 encounter records did not include the required data element Ingredient Cost Paid to Pharmacy.
- 371,910 encounter records did not include the MCO Payment Amount reported to DMAS.
- 125,882 encounter records were reversals of claims processed prior to the required reporting of detailed payment amounts.

The removal of those records resulted in 73.28 percent of records, or 2,076,512 encounters, eligible for evaluation. DMAS staff who works with managed care plans to ensure claim accuracy will contact the plans to discuss encounter transactions that were submitted without the required data elements. These staff will handle only non-financial claim information.

Several anomalies were discovered when reported payment amounts were compared. Encounter records that require further research, including contact with the submitting plans, include the following:

- A single encounter claim with an MCO-reported payment amount more than $186,000 above the reported payment to the pharmacy provider. This encounter was excluded from the total reported below.
- Encounters reporting a “patient paid amount” though no member copays are allowed in managed care plans. This appears to be a PBM or MCO attempting to report other health insurance payments, but the encounters must be investigated and verified.
- Encounter transactions for which the amount reported to DMAS as paid by the MCO was less than the amount reported as paid to the pharmacy provider (see table below). These encounters will require further investigation because DMAS would not expect the PBMs and MCOs to be losing money on a pharmacy transaction.

Prescription Encounter Claims with Negative Variance

(reported MCO payment less than reported payment to pharmacy)

Date Span	Claim Count	Dollar Variance	Avg./Claim	Minimum	Maximum
< 07/01/2017	651	-$8,528.44	-$13.10	-$0.01	-$444.80
07/01/2017-07/31/2017	118,349	-$703,011.17	-$5.94	-$0.01	-$2,367.39
08/01/2017-08/31/2017	128,255	-$951,038.44	-$7.42	-$0.01	-$4,106.85
09/01/2017-09/21/2017	101,186	-$853,566.41	-$8.44	-$0.01	-$4,106.85

After correcting for the above anomalies, a total of 1,575,821, or 75.89 percent of the 2,076,512 eligible claims, were available for analysis.

The reported MCO payment was greater than the amount paid to the pharmacy for 152,250, or 7.33 percent, of the 2,076,512 claims analyzed. The average difference per claim was approximately $22.72. Extrapolating from a single quarter of data, this results in an estimated annual total of $13,834,118 in reported MCO payment amounts to the PBMs in excess of payments to pharmacies**.** As noted in the limitations section below, extrapolating an annual total from the first quarter of data that has identified opportunities for feedback, corrections, and data quality improvements on the part of the submitting MCOs may introduce a level of variance in the projected 4 quarter total. The projected total likely underestimates the annual impact because 26.72 percent of the total submitted encounters were missing required data elements and could not be included in this analysis.

The following table presents the aggregated view of encounter transactions by MCO reported month, and includes the total cost variance, average cost variance per claim, and maximum variance by month.

Prescription Encounter Claims with Positive Variance

(reported MCO payment greater than reported payment to pharmacy)

Date Span	Claim Count	Dollar Variance	Avg./Claim	Minimum	Maximum
< 07/01/2017	1,788	$19,026.87	$10.64	$0.01	$465.78
07/01/2017-07/31/2017	69,150	$1,350,559.36	$19.53	$0.01	$2,555.06
08/01/2017-08/31/2017	50,869	$1,204,285.19	$23.67	$0.01	$3,371.27
09/01/2017-09/21/2017	30,443	$884,658.10	$29.06	$0.01	$4,931.94

Further encounter detail analysis will be required in subsequent quarters because no distinct pattern of differences in reported payment amounts was identified in the small sample available for this PBM Transparency Report. DMAS is currently developing a template for the MCOs to use when providing the itemization of all fees, processing charges, or other administrative pricing elements that comprise the dollar variance between the amount the MCO paid to their PBM and the amount that the PBM paid to the pharmacy for the prescription. This template will be reviewed with the pharmacy directors of the various MCOs for their input and comments. DMAS will deliver the template along with the requested claims to the MCOs for additional reporting. The final versions of the additional detail requested of the MCOs will be due to the department as of May 1, 2018. DMAS will review, summarize, and report on the additional information provided in fall of 2018.

Limitations

Only one quarter of encounter claim data was available for analysis in the production of this report. The volume of data collected in a single quarter is not sufficient to make accurate conclusions about the relative impact of various pricing models.

DMAS will continue to work with the submitting plans to improve the data integrity and data quality of their submitted prescription encounters. DMAS is working to eliminate or minimize the volume of claims that must be removed from the data review and analysis of payment details as noted in the anomalies above with the ultimate goal of providing a meaningful, accurate, and comprehensive review that fulfills the mandate from the General Assembly.

Future Opportunities

Data collected over a full year of prescription encounter claims will produce a more robust and complete representation of the various managed care and PBM contract models present in the Virginia Medicaid program. With higher data integrity and quality in the MCO encounter submissions and MCO reported additional price detail, the relative merits of each model can be evaluated for impact on the prescription drug spending required to meet the needs of Virginia Medicaid members.

This required reporting process can inform continued efforts to increase the integrity and quality of the MCO encounter data submitted to DMAS. These efforts include a new encounter data scorecard developed as a component of the Enterprise Data Warehouse to measure the accuracy, reliability, and timeliness of encounter data. In addition, language in the CCC Plus and Medallion 4.0 contracts strengthens the penalties for submission of poor quality data. These actions address recommendations regarding the improvement of data collection for better oversight of MCO spending in the 2016 JLARC report *Managing Spending in Virginia's Medicaid Program.*

Summary

- The total number of claims in the first quarter of FY 2018 for which the reported MCO payment was greater than the amount paid to the pharmacy was 152,250, or 7.33 percent of all claims analyzed. The average difference per claim was approximately $22.72.
- Extrapolating from a single quarter of data, this results in an estimated annual total of $13,834,118 in reported MCO payment amounts to PBMs in excess of payments to pharmacies.
- DMAS will work toward the development of a pharmacy claims data quality scorecard that will ensure that all data elements required by the General Assembly mandate are submitted by the PBMs and MCOs and can be analyzed in a future report.